



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
C/O SULLINS JOHNSTON RORBACH & MAGERS
2200 PHOENIX TOWER
3200 SOUTHWEST FREEWAY
HOUSTON TX 77027-7533

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-07-3582-01

MFDR Date Received

February 7, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Because this admission was for out-patient surgery, there is no particular fee schedule and the hospital should be reimbursed at a fair and reasonable rate. The carrier instead paid a fraction of the Operating Room expenses and denied all other charges using an unknown method of calculating benefits. The payment by the carrier amounts to less than 5% reimbursement on this surgery which is inherently unfair and unreasonable. On its face, the amount paid by the carrier for this surgery is wholly unreasonable under any discernable standard. . . . Since the insurance carrier did not conduct an in-house or desk audit on these medical expenses, Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred. The carrier paid a total of \$1,893.13 on this surgery. Requestor is owed an additional \$29,339.70 on this surgery, plus interest."

Amount in Dispute: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue in dispute is the requestor's a) failure to substantiate that its usual and customary fee for the service in dispute is fair and reasonable as required by Rule 134.1(f) and Section 413.011(d) of the Texas Labor Code; and b) failure to prove Texas Mutual's payment is not fair and reasonable. . . . The Department of Worker' Compensation, then the Commission, contracted with Ingenix, Inc., in 2002 to develop MARs for a hospital outpatient fee guideline. Ingenix recommended to the Commission that a market reimbursement of 140% of Medicare's Hospital Outpatient Prospective Payment System would meet the statutory requirements of Section 413.011(d). (Exhibit 2) . . . The requestor listed code 29899 on its bill. (See requestor's DWC-60 packet) The APC code is 0042. . . . The 2006 HOPPS median payment for code 29881 is \$1,673.05. . . . To convert to the Ingenix recommended MAR \$2,630.83 is multiplied by 140% which equals \$3,683.16."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2006	Outpatient Hospital Services	\$500.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REIMBURSEMENT MADE BASED ON INSURANCE CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY.
 - CAC-W4 – NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
 - CAC-143 – PORTION OF PAYMENT DEFERRED.
 - 420 – SUPPLEMENTAL PAYMENT.
 - 426 – REIMBURSED TO FAIR AND REASONABLE.
 - 713 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.
 - 891 – THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION.
 - 894 – FAIR AND REASONABLE REIMBURSEMENT FOR THE ENTIRE BILL IS MADE ON THE 'O/R SERVICE' LINE ITEM.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
4. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Requestor submits that a fair and reasonable rate for surgeries performed on this employee are the usual and customary charges incurred."
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - The requestor did not submit documentation to support that the charges billed are the facility's usual and customary charges for the services in dispute.

- The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered . . . and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges . . .” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

October 18, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.